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IN THE

Supreme Court of the United States

October Term, 1989

NANCY BETH CRUZAN, by her parents and co-guardians, LESTER L. and JOYCE CRUZAN

Petitioner,

vs.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,

Respondents,

vs.

THAD C. MCCANSE, Guardian ad litem,

Respondent.

On Writ of Certiorari
to the
Missouri Supreme Court

BRIEF AMICUS CURIAE OF THE AMERICAN ACADEMY OF MEDICAL ETHICS IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED HEREIN

Does the United States Constitution require a state to authorize a court appointed guardian to cause the death of a dependent ward by denying the ward food and fluids when she is not terminally ill and there is no clear and convincing evidence of her intent?

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INTEREST OF AMICUS[1]

The American Academy of Medical Ethics is an educational and lobbying organization with approximately 20,000 associated physicians, incorporated in 1986 to respond to the challenges of current trends in medical ethics. The Academy follows the Hippocratic Oath in holding that the first duty of a physician is that he do the patient no harm. The Academy asks the Court to affirm the decision of the Supreme Court of Missouri because the withholding of food and fluids always constitutes a harm to incompetent and dependent wards when they are not terminally ill and there is no clear and convincing evidence of their intent.

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[1] This Brief Amicus Curiae is filed with the consent of all parties to this appeal. A letter from each attorney stating this consent has been filed with the Clerk of this Court.

SUMMARY OF THE ARGUMENT

This is a case in which the guardian of Nancy Cruzan, a dependent ward, requests court authorization to make Nancy die by starvation and dehydration. The guardian is requesting the recognition of a constitutional right to choose death for Nancy Cruzan. Nancy is not terminally ill and the guardian has not presented clear and convincing evidence of Nancy's intent. The presence of the feeding tube is not an issue because the guardian's expert testimony states that the tube should be left in place for medicinal purposes.

The purpose of this brief is to show that the decision of the Missouri Supreme Court is in the best interests of persons who are incompetent, whose diagnoses indicate the likelihood of permanent unconsciousness, and who are unable to receive nutrients by mouth. The argument consists of five parts.

First, the decision of the Missouri Supreme Court is supported by the legal analyses and conclusions of other courts and jurists in cases involving similar circumstances. The Washington Supreme Court in *In re Grant* and the New York Court of Appeals in *In re Westchester County Medical Center* are in essential agreement with the *Cruzan* court. Even those courts who authorized guardians to choose death for their wards expressed a certain amount of unease in their opinions.

Second, the *Cruzan* decision is supported by the medical facts which demonstrate that feeding by tube is in the ward's best interests. Feeding by tube has a long history and is necessary to preserve the lives of many persons with various disabilities. Scholarly studies reveal that feeding by tube is not physically or economically burdensome.

Third, the decision is supported by philosophical distinctions which demonstrate that feeding by tube constitutes ordinary care, not medical treatment. Withholding food and fluids is distinguishable from the withholding of medical treatment in that: the former always results in death, the later usually does not; withholding food and fluids is inconsistent with the ethical

integrity of the medical profession; feeding by tube is not artificial, but is the provision of real nutrition to the ward; and the fact that a tube is used does not transform the procedure into elective medical therapy.

Fourth, the decision is supported by traditional health care ethics which demonstrate that the withholding of food and fluids without informed consent constitutes nonvoluntary euthanasia. Withholding of nutrition in order to cause death constitutes a form of euthanasia. Nonvoluntary euthanasia occurs when the ward has not given informed consent to the withholding of nutrition in the past, and is incapable of giving informed consent in the present.

And fifth, the decision is supported by the alarming historical effects of legalized euthanasia as observed in the Netherlands. The readily observable effects include: constantly expanding indications for euthanasia; confusion over the number of people receiving euthanasia due to falsification of death certificates; opposition to legalization of euthanasia and fear of involuntary euthanasia by nursing home residents; coincidental reduction of public health care benefits for older persons; and a lack of consensus of opinion among doctors, lawyers, legislators and society as a whole.

ARGUMENT

> This is a case in which we are asked to allow the medical profession to make Nancy die by starvation and dehydration. The debate here is thus not between life and death; it is between quality of life and death. We are asked to hold that the cost of maintaining Nancy's present life is too great when weighed against the benefit that life conveys both to Nancy and her loved ones and that she must die.

Cruzan v. Harmon, 760 S.W.2d 408, 412 (Mo.banc 1988). This

statement of the Missouri Supreme Court cuts to the heart of the issues before this Court. Nancy Cruzan is not terminally ill. *Id.* No clear and convincing evidence exists as to her intentions regarding refusal of food and fluids. *Id.* at 424. Her guardian wants to cause her death by withholding food and fluids from her, leaving her feeding tube in place, but unused, except for medications.

The guardian is, therefore, requesting the right to choose death for Nancy Cruzan. The feeding tube is not physically burdensome. The guardian's expert witness has testified that the tube should be left in place so that medications may be given to Nancy. The feedings themselves are not burdensome, either physically or economically. The issue is death. Does the United States Constitution require a state to authorize a court appointed guardian to cause the death of a dependent ward by denying the ward food and fluids when she is not terminally ill and when there is no clear and convincing evidence of her intent?

The purpose of this brief is to show that the decision of the Missouri Supreme Court is in the best interests of persons who are incompetent, whose diagnoses indicate the likelihood of permanent unconsciousness, and who are unable to receive nutrients by mouth. The argument consists of five parts. First, the decision of the Missouri Supreme Court is supported by the legal analyses and conclusions of other courts and jurists in cases involving similar circumstances. Second, the decision is supported by the medical facts which demonstrate that feeding by tube is in the ward's best interests. Third, the decision is supported by philosophical distinctions which demonstrate that feeding by tube constitutes ordinary care, not medical treatment. Fourth, the decision is supported by traditional health care ethics which demonstrate that the withholding food and fluids without informed consent constitutes nonvoluntary euthanasia. And fifth, the decision is supported by the alarming historical effects of legalized euthanasia as observed in the Netherlands.

I. THE GUARDIAN HAS CHOSEN DEATH FOR NANCY CRUZAN.

The decision of the Missouri Supreme Court has correctly identified the issue as involving the guardian's right to choose death for Nancy Cruzan. Its analysis is supported by the legal analyses and conclusions of other courts and jurists in cases involving similar circumstances.

Beginning in 1976, with *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), there have been over one hundred cases involving the withdrawal of life-sustaining medical treatment or food and fluids for incompetent and, in a few cases, competent patients. The majority of states have had at least one case; twelve have reached the highest state courts. The number of cases have accelerated in recent years.

Beginning in 1988, those in favor of the trend in these cases were proclaiming that a "consensus" had arisen in favor of withdrawing life-sustaining food and fluids from incompetent patients. By the end of 1988, however, a counter trend emerged with roots in previous lower court opinions, in dissents in recent right to die appellate opinions, and culminating in the decisions of the Supreme Court of Washington, in *In re Grant*, 109 Wash.2d 545, 747 P.2d 445 (1987), *modified*, 757 P.2d 534 (1988), the New York Court of Appeals, in *In re Westchester County Medical Center*, 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988), and the Missouri Supreme Court in *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo.banc 1988). In these three cases, state supreme courts refused to authorize the withdrawal of food and fluids from incompetent patients who were not terminally ill, absent an informed refusal of care by the patient while the patient was competent.

The *Cruzan* court refused to define feeding by tube as medical treatment, since "common sense tells us that food and water do not treat an illness, they maintain a life." 760 S.W.2d at 423. The *Grant* plurality agreed and stated "that the right to face an inevitable and imminent death in a manner most consistent

with our beliefs and with our dignity as humans is vital. . . . (However,) by authorizing the withholding of intravenous nutrition and hydration, (the court would be authorizing) death by starvation and dehydration. . . . (F)or all intents and purposes the (court would be authorizing) mercy killing, arguably of a cruel nature." 747 P.2d at 461. The New York Court of Appeals viewed the issue as whether Mary O'Connor intended "to choose death by starvation and thirst in her present condition." 534 N.Y.S.2d at 894 n.5. Thus, the nature of withdrawal of food and fluids has led these courts to view these cases as involving the right of a guardian to choose death for an incompetent patient. They then concluded that the respective guardians have no right to choose death for their wards.

Even those courts who authorized guardians to choose death for their wards expressed a certain amount of unease in their opinions. Many called upon the state legislature to create standards governing these cases on the basis that they are better able to deal with the complex issues of medicine, law and ethics which are involved. *See, e.g., In re Farrell*, 108 N.J. 335, 529 A.2d 404, 407 (1987). For instance, Justice Handler of the New Jersey Supreme Court expressed discomfort when he said: "In the final analysis, we are struggling to structure a decisional framework that will generate trust, confidence and acceptance. Our unease and dissatisfaction with particular right to die opinions mirror our failure thus far to achieve this level of assurance. The problems of trust and distrust hover over these cases. . . . Decisions of such painful difficulty cannot be so easily rejected or so quickly applauded. Given . . . the complexity of the issues involved in the right to die cases, no substantive or procedural standard will ever be able completely to dispel or hide the doubt engendered by those treatment decisions; achievement of trust and confidence will be painstaking." *In re Jobes*, 108 N.J. 335, 529 A.2d 404, 461 (1987) (Handler, Clifford, Pollock, J.J., concurring).

Thus, courts on both sides of the issue demonstrate a recognition that a choice of death is the crux of the matter. This

recognition of the issue as involving a choice of death by a guardian for an incompetent ward supports the Missouri Supreme Court's analysis and holding that neither common law nor constitutional law justifies such a choice for Nancy Cruzan.

II. FEEDING BY TUBE IS IN THE WARD'S BEST INTERESTS.

The decision of the Missouri Supreme Court is also supported by the medical facts which demonstrate that feeding by tube is in the ward's best interests. When a patient is unable to take nutrients by mouth, feeding by tube is in the person's best interests. The only exception to this rule is when the person's death is imminent. May, Barry, Griese, Grisez, Johnstone, Marzen, McHugh, Meilaender, Siegler & Smith, *Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons*, 3 Issues in Law & Med. 203, 209 (1987). In order to properly evaluate the benefits and burdens of feeding by tube it is necessary to understand something of the history of feeding by tube, the necessity of feeding by tube for patients with various disabilities, the physical burdens of feeding by tube, and the economic burdens of feeding by tube. Only after evaluating such information can feeding by tube be seen for what it is, an alternative to oral ingestion of required nutrients.

A. FEEDING BY TUBE HAS A LONG HISTORY.

John Hunter, a well respected American doctor and surgeon, is credited with using nasogastric feeding tubes for the first time in 1790 for the benefit of a patient who was paralyzed. Mequid, Eldar & Wahba, *The Delivery of Nutritional Support: A Potpourri of New Devices and Methods*, 55 Cancer 279 (1985). Dr. Hunter, in a speech on September 21, 1790, described the benefits of feeding by tube for patients suffering paralysis of the throat preventing swallowing:

> As this disease is only rendered dangerous from the want of a substitute for deglutition [swallowing], it becomes our duty to adopt some artificial mode of conveying food into the stomach, by which the

> patient may be kept alive while the disease continues, and such medicines may be administered as are thought conducive to the cure.

J. Hunter, *A Case of Paralysis of the Muscles of Deglutition, Cured by an Artificial Mode of Conveying Food and Medicine into the Stomach (Sept. 21, 1790), published in* J. Palmer, *The Works of John Hunter, H.R.S.* 622, 623 (1837). The first nasogastric feeding tube was fashioned from a fresh eel-skin. The patient received feedings twice daily and eventually recovered. *Id.*

Stomachs were first operated on by Hippocrates, Galen and others to repair injuries caused by stab wounds received in combat. Cunha, *Gastrostomy: Its Inception and Evolution*, 72 Am. J. Surg. 610, 615 (1946). The first operations performed on stomachs, other than for repair, occurred in the 15th century for the removal of objects swallowed accidentally. *Id.* at 611, 616.

In 1812, Dr. Phillip Physick made use of the first stomach tube to cleanse the stomachs of three month old twins who had been given an overdose of laudanum. Smithies, *Priority in the "Invention" and Employment of the Stomach Tube*, 84 JAMA 914 (1925).

In 1822, Dr. William Beaumont, a United States Army surgeon, was the first person to insert food into the stomach of a patient and observe digestion. W. Beaumont, *Experience and Observations on the Gastric Juice and the Physiology of Digestion* 38-50 (1833). The patient, Alexis St. Martin, was the victim of an accidental musket shooting. He was the first person to live in health with a permanent opening into the stomach (Dr. Beaumont was unable to close the severely perforated stomach). *Id.* at 11, 12; Cunha, *supra*, at 631.

In 1837, Egeberg, a Norwegian Army surgeon lecturing in Copenhagen, first proposed a gastrostomy — the "creation of an artificial opening into the stomach from the outside for the purpose of introducing food or medications." Cunha, *supra*, at

612. He explained: "I cannot see why the indications should not be just as great to open the intestinal canal to put nourishment in as to open it to take a foreign body out." *Id.* at 631. In 1845, a French surgeon, Sedillot of Strasbourg, was credited with performing the first gastrostomy on a patient with cancer of the esophagus. *Id.* at 614.

In 1856, the renowned Strasbourg surgeon, Fontan, invented the first serviceable tube with a valve-like mechanism at the stomach end which prevented leakage. *Id.* at 617. By 1930, Denk, professor at the University at Graz, Austria, was routinely performing gastrostomies for young suicide attempters who had swallowed lye. *Id.* Thus, feeding by tube has a long and profound history of sustaining life for people with an inability to swallow.

B. FEEDING BY TUBE IS NECESSARY TO PRESERVE THE LIVES OF MANY PERSONS WITH VARIOUS DISABILITIES.

Feeding by tube is necessary for many people who are unable to eat or swallow food due to a variety of ailments. There are four general catagories of persons that require feeding by tube. First, some people have an impaired ability to ingest nutrients. This includes people with neurological disorders (Alzheimer's disease, stroke, Parkinson's disease, head injury or comatose patient); cancers of the mouth, esophagus, head, or neck; wired or fractured jaw; multiple sclerosis; and severe chronic obstructive pulmonary disease. *Id.*

Second, some people have an impaired ability to digest nutrients. This includes people with cystic fibrosis, pancreatic dysfunction, liver disease, gastrectomy, and cancers of the stomach, liver or pancreas. *Id.*

Third, some people have an impaired ability to absorb nutrients. This includes people with gastrointestinal side effects of cancer therapy, short bowel syndrome, malabsorptive disorders, Crohn's disease, enteritis, ulcerative colitis, cancers involving the small or large bowel, fistulas of the

small or large bowel, and radiation enteritis. *Id.*

Fourth, some people have other impairments not described above. This includes people with severe depression, failure to thrive, chronic pulmonary disease, and renal or cardiac disease. *Id.*

It is evident from this brief survey of indications for tubal feeding that many people benefit from this nutritional support. In 1985, home delivery of nutritional support in the United States included two to five thousand people on parenteral (intravenous) feedings and fifteen to twenty thousand people on enteral (gastrointestinal) feedings. Howard, Heaphey & Timchalk, *Review of the Current National Status of Home Parenteral and Enteral Nutrition From the Provider and Consumer Perspective*, 10 J. Parenteral & Enteral Nutrition 416, 417 (1986). Ten to twenty percent of the people on home delivery of nutritional support were below the age of twenty, and twenty percent were above the age of sixty-five. *Id.* at 418. More than fifty percent were between the ages of fifty and sixty-five. Feeding by tube is necessary to preserve the lives of many patients with various disabilities.

C. FEEDING BY TUBE IS NOT PHYSICALLY BURDENSOME.

To the untrained ear feeding by tube sounds burdensome, restrictive and suitable only for persons who are relatively inactive. Such is not the case. Feeding by tube is not physically burdensome.

There are four basic delivery methods. First, the nasogastric tube (NG tube) has been used since 1790 for delivering enteral nutrition. Mequid, Eldar & Wahba, *supra*, at 279. In this method a tube is inserted into the nostril and threaded down the esophagus and into the stomach. Cogen & Weinryb, *Tube Feeding: Providing the Most Nutrition With the Least Discomfort*, 85 Postgraduate Med. 355 (1989). The NG tube is the easiest and least expensive delivery method. The duration of feeding is relatively short. However, medical authorities recommend that NG tubes or nasojejunostomy tubes be used for no longer than six weeks because of possible complications such as scarring and narrowing of the nasal and throat passages, and infection of the sinuses. Mequid, Eldar & Wahba, *supra*, at 280.

Generally, people find this method somewhat uncomfortable and distressing. Cogen & Weinryb, *supra*, at 355. However, working adults may opt to receive enteral feeding during sleep by inserting their own feeding tubes. Berezin, *Home Teaching of Nocturnal Nasogastric Feeding*, 5 J. Parenteral & Enteral Nutrition 125 (1981). Young adults and adolescents sometimes opt to insert their own tubes for nocturnal feedings as well. *Id.*

Second, a gastrostomy tube (G tube) is used whenever the necessity of feeding by tube is expected to continue for an extended period of time. A G tube is inserted directly into the stomach through the abdominal wall. Originally, such placement required surgery. Cogen & Weinryb, *supra*, at 355.

The preferred method of placement is endoscopic placement. This method eliminates the need for surgery. Endoscopic placement utilizes an endoscope (a long tube with a light at the end) which is swallowed by the patient. When the light on the tip shows in the appropriate area of the stomach, the doctor mades a small incision and attaches suture material to the end of the endoscope. The endoscope is then withdrawn back through the mouth with the suture material attached. The other end of the suture material is attached to the G tube which is pulled through the small abdominal incision until properly placed for feeding. *Id.* at 355-56.

Third, the jejunostomy tube (J tube) is considered to be the safest method of enteral feeding. Rives, LeRoy, Hawkins & Bowden, *Endoscopically Assisted Nasojejunal Feeding Tube Placement*, Am. Surgeon, Feb. 1989, at 88, 90. The jejunum is part of the small intestine, approximately twelve inches from the stomach. A J tube can be placed surgically or with an endoscope procedure similar to that described above. Cogen & Weinryb, *supra*, at 356. Modern surgical procedures have prac-

tically eliminated problems with leakage, infection, hematoma, and accidental removal. McGonigal, Lucas & Ledgerwood, *Feeding Jejunostomy in Patients Who Are Critically Ill*, 168 Surgery, Gynecology & Obstetrics 275, 277 (1989).

Fourth, the gastrostomy button is a new skin-level feeding device which is replacing conventional G or J tubes. Foutch, Talbert, Gaines & Sanowski, *The Gastrostomy Button: A Prospective Assessment of Safety, Success, and Spectrum of Use*, 35 Gastrointestinal Endoscopy 41, 43 (1989). Gastrostomy buttons are placed in existing gastrostomy openings and have a success rate of ninety percent. *Id.* at 44. It is suitable for ambulatory as well as confined patients.

Once the tube is in place, there are a variety of feeding methods possible depending upon the needs of the patient. McCrae & Hall, *Current Practices for Home Enteral Nutrition*, 89 J. Am. Dietetic A. 233, 235 (1989). The intermittent bolus method involves the delivery of blenderized food several times per day. The boluses are inexpensive, approximate the consistency of a normal diet and do not require a pump. *Id.*

Intermittent gravity drip feedings are infused several times per day over a period of thirty to ninety minutes. They are relatively simple and inexpensive to administer, do not require a pump, simulate a normal feeding pattern, and are suited to patients who do not require a precisely regulated flow. *Id.*

Continuously infused feedings often require an infusion pump for accurate delivery. The chief disadvantages of continuous feeding are increased expense and restricted patient mobility. *Id.*

Cyclic feedings are continuously infused over a period of six or more hours. Nocturnal cyclic feedings encourage ambulation and oral food consumption during the day. *Id.*

As indicated above, there are two basic feeding formulas. Blenderized feedings are the least expensive but are more time-consuming to prepare. Cogen & Weinryb, *supra*, at 357.

Commercially prepared feedings are easy to give and contain a complete diet. Konstantinides & Shronts, *Tube Feeding: Managing the Basics*, 83 Am. J. Nursing 1312, 1316 (1983).

With this variety of delivery methods, feeding methods and feeding formulas, feeding by tube can be adapted to the needs of each patient. Such feedings have been found to be safe, economical and well tolerated by most patients. Torosian & Rombeau, *Feeding by Tube Enterostomy*, 150 Surgery, Gynecology & Obstetrics 918, 924 (1980).

A study was conducted in which data was analyzed from thirty patients who were receiving feedings by NG tubes. Padilla, Grant, Wong, Hansen, Hanson, Bergstrom & Kubo, *Subjective Distresses of Nasogastric Tube Feedings*, 3 J. Parenteral & Enteral Nutrition 53 (1979). The patients were asked to rank a list of common experiences shared by hospital patients who were also receiving enteral feedings. Score values ranged from 3.000 (least distressing) to 6.000 (most distressing). *Id.* at 55. The least distressing experience commonly felt was wearing an identification band (3.000) while the most distressing experience was pain from surgery or disease (5.048). *Id.* Having a tube in the nose had a mean score of only 4.133. Experiences more distressing than having a tube in the nose included feeling thirsty (4.813), being away from home and family (4.778), losing control of daily activities (4.680), and being deprived of chewing food (4.231). Taking food by tube with a different appearance than usual had a mean score of 3.069, and taking food by tube with a different consistency than usual was 3.040, just above wearing an identification band. *Id.*

Thus, the level of distress for feeding by a NG tube is very low. As noted above, the NG tube causes more distress than any other method of enteral feeding. When considering a patient in a coma or persistent vegitative state, the level of distress or physical burden could be considered negligible. Therefore, it may be concluded that feeding by tube is not physically burdensome.

D. FEEDING BY TUBE IS NOT ECONOMICALLY BURDENSOME.

The cost of formula for feedings by tube and the provision of the required equipment compares favorably with the costs of prepared meals. In fact, table food can be blenderized and used for the feedings of some patients. Cogan & Weinryb, *supra*, at 357. Drs. Torosian and Rombeau describe the advantages of enteral nutritional therapy:

> When comparing costs of nutritional therapy, it is essential to review the costs of regular meals for hospitalized patients. In many hospitals, the total cost of purchasing, preparing and delivering these meals will vary between fifteen and twenty dollars per patient each day. In addition, there is no assurance that these meals will be consumed. This is contrasted with tube feeings in which a specific feeding regimen is ordered and administered with reasonable certainty. The cost of enteral nutritional therapy will vary depending upon the type and amount of diet administered. Even when the most expensive enteral diets are used, the cost is not unduly greater than the standard hospital meals.

Torosian & Rombeau, *supra*, at 918.

Feedings by tube are easily administered. There are few problems associated with tubal feedings. Parrish & Cohen, *Temporary Tube Gastrostomy*, 38 Am. Surgery 168 (1972). The medical equipment (tubes, syringes and plastic feeding bags) are easy to manage and maintain and do not require sterilization. Torosian & Rombeau, *supra*, at 918. Commercial feeding solutions are ready for use with the opening of the premixed formula. Konstantinides & Shronts, *supra*, at 1316.

A fourteen day study was conducted in Minnesota comparing the costs of four different methods of providing complete nutritional support: intervenous glucose, hyperalimentation through vein in the arms and hands, hyperalimentation

through large veins in the chest, and enteral tube feedings. Roberts, Thelen & Weinstein, *Parenteral and Enteral Nutrition: A Cost Benefit Audit*, 65 Minn. Med. 707, 708-09 (1982). The daily costs, including all necessary equipment, laboratory testing, and monitoring by health care professionals ranges from $21.00 for enteral feedings to $200.00 for large vein hyperalimentation. *Id.* The researchers concluded: "Enteral hyperalimentation, or tube feedings, are generally under utilized. They cost the patient only $21.00 per day, yet they can meet the caloric needs of most patients." *Id.* at 707.

Hospital or nursing home enteral feedings are covered both by Medicare and private insurance companies. Medicare will reimburse eighty percent of the allowable charges of enteral feedings with the appropriate medical documentation and the expectation that the feedings will last more than ninety days. McCrae & Hall, *supra*, at 239. Although private insurance companies have differing policies regarding enteral feedings, many will agree to pay for the feedings at home if cost containment can be proved. *Id.* Medicaid coverage varies from state to state, from full reimbursement to no reimbursement. *Id.*

Feedings by tube do not require skilled nursing care. Enteral nutrition support is accepted today as a safe and viable means of providing nutrients to persons who cannot eat. For many patients who do not require institutionalization in an acute-care or long-term-care facility, enteral feedings at home are a viable alternative. McCrae & Hall, *supra*, at 233. "The nutritional support allows patients to return to a comfortable home environment, thereby avoiding lengthy institutionalization. In some cases, the nutrition makes a critical contribution to a patient's complete recovery." American Dietetic Ass'n, *Position of the American Dietetic Association: Nutrition Monitoring of the Home Parenteral and Enteral Patient*, 89 J. Am. Dietetic A. 263 (1989). "Minimally skilled nursing personnel or the patient's family can easily be taught stomal care, replacing the catheter if necessary, and administering tube feeding." Pomerantz, Salomon & Dunn, *Permanent Gas-*

trostomy as a Solution to Some Nutritional Problems in the Elderly, 28 J. Am. Geriatrics Soc'y 104, 107 (1980). Thus, it can be concluded that feeding by tube is not economically burdensome.

Nancy Cruzan has a gastrostomy tube which is a safe and economical way to give her food and fluids. Her feeding does not require significant nursing time. Nancy's feeding is inexpensive. It costs only $234.00 per month for enteral formula or $7.80 per day. This is only 2.6% of the total cost of care. Letter from Donald Lamkins, Administrator of the Missouri Rahabilitation Center, dated August 10, 1989 (Appendix A).

If feeding by tube is not physically or economically burdensome, then the burdens associated with the feeding itself cannot be justification for the withholding of food and fluids from Nancy Cruzan. Indeed, the transcript shows that the presence of the tube is not at issue since it would be beneficial to retain it for medicinal purposes even if food and essential fluids are discontinued. Dr. Cranford, an expert witness for the guardian, testified as follows:

> A. . . . I think probably be better to keep the gastrostomy in place and continue the anticonvulsants that was than maintaining an IV and giving fluids that way.
>
> Q. That was really, I think, what I was heading for. You would recommend leaving the tube in, but not giving food and water?
>
> A. Yes. I would leave the tube in —
>
> Q. Except enough to give the anticonvulsant medication?
>
> A. Yes, yes.

TR. 490. If the presence of the tube is not the issue, then the only issue is whether food and fluids should be withheld from Nancy Cruzan.

The medical facts regarding feeding by tube demonstrate that the provision of food and fluids by tube is in Nancy Cruzan's best interests. The medical facts regarding feeding by tube do not support the guardian's request for court authorization to choose death for Nancy Cruzan.

III. FEEDING BY TUBE CONSTITUTES ORDINARY CARE NOT MEDICAL TREATMENT.

The Supreme Court of Missouri summed up the practical problem this way: "She is not dead. She is not terminally ill. Medical experts testified that she could live another thirty years." *Cruzan*, 760 S.W.2d at 411. The guardian prefers her death to her living in a noncommunicative and inactive state.

Withdrawal and withholding of life-sustaining treatment has been approved by the courts in a variety of situations. But is the provision of food and fluids different from life-sustaining medical treatment? If so, how is it different?

On its surface, eating and drinking is different from medical treatment as to the purposes served. As one author stated:

> Medical treatment is aimed at curing a disease. Eating and drinking are not aimed at curing a disease, but at sustaining life. Medical treatment is therapeutic; eating and drinking are not basically therapeutic.

Connery, *The Ethical Standards for Withholding/Withdrawing Nutrition and Hydration*, 2 Issues in Law & Med. 87 (1986). On analysis, there are at least five ways to distinguish feeding by tube from medical treatment.

First, withholding food and fluids is distinguishable from the withholding of medical treatment in that the former always results in death, the later usually does not. This aspect of finality has been aptly described by philosopher Patrick Derr:

> The withholding or withdrawal of food and fluids is

biologically "final" in a way, and with a degree of epistemic certainty, that the withholding or withdrawal of medical or surgical therapy is not. The withholding or withdrawal of specific, medically indicated medical or surgical treatment does not guarantee that the patient will die: Karen Quinlan confounded all the expert medical opinion by surviving the withdrawal of artificial respiratory support, and Jehovah's Witnesses sometimes confound expert medical opinion by surviving the withholding of medically necessary blood transfusions. But it is never possible for a given patient to survive the withholding or withdrawal of food and fluids. The withholding or withdrawal of food and fluids is biologically final. It guarantees the death of the patient; with a degree of certainty that the withholding or withdrawal of medical or surgical therapy never provides.

Derr, *Nutrition and Hydration as Elective Therapy: Brophy and Jobes from an Ethical and Historical Perspective*, 2 Issues in Law & Med. 25, 28 (1986).

Second, withholding food and fluids is inconsistent with the ethical integrity of the medical profession. It is distinguishable from the withholding of medical treatment by its effects upon the integrity of the medical profession as a learned and ethical profession. *Id.* at 30.

Medicine and law are considered to be learned professions. They are considered "learned" because their practice requires special knowledge. They are considered "professional" because they profess a set of normative or ethical commitments. The ultimate value in law is justice. The ultimate value in medicine is life, or more particularly, the protection, preservation and improvement of life and health. Thus, if a lawyer becomes indifferent to injustice, he has abandoned law as an ethical profession. If a physician becomes indifferent to sickness and death, he has abandoned medicine as an ethical profession. *Id.* at 31.

A decision to compel or permit a physician to withhold food and fluids from patients who are capable of receiving them directly attacks the very foundation of medicine as an ethical profession. The effect of withholding of nutrients in order to cause death, once accepted, has two contrary results: (1) it reduces the practice of medicine to the level of a skilled technician "without ultimate normative commitments," *Id.* at 32; and (2) it grants autonomy to third party decisionmakers, who have the power to terminate patients who are unable to decide for themselves. If such a commitment to ethical norms is lost, and if the effect of such a loss is later determined to be disastrous for medicine as a profession and society as a whole, the return to such a principle of absolute respect for life will be very difficult. Killing, once accepted, is too convenient a solution (both medically and economically) for too many difficult medical situations.

Third, food and fluids have special cultural and symbolic significance; medical treatments do not. *Id.* at 33. There are no more powerful symbols than food and water. Hunger and thirst are common to all people. Food and water represent the primary means of aid to those in need. Our most important events in life are associated with food and drink: birthdays, weddings, anniversaries, religious ceremonies, and funerals. "Our most powerful image of maternal love is the mother suckling the baby at her breast." *Id.* at 34. The provision of food and fluids to people who are unable to eat consitutes the minimum level of humane care.

Fourth, feeding by tube is not artificial. *Id.* at 34. The distinction between the withholding of food and fluids and the withholding of medical treatment remains valid even when the provision of nutrients is accomplished by tube. Although the normal channel of ingestion is being bypassed, the nutrients are real, not artificial. Almost all food is now processed with machines. Certainly, the food and fluids provided commercially for enteral feedings is just as real (and certainly more nutritious) as the hamburger, fries and milk shakes which so

frequently fill our dietary needs. The means of procurement does not determine the character of the substance. Nutrients are nutrients, whether received by mouth or by tube. Nutrients do not become medicines simply because they are provided through a tube.

Fifth, the provision of food and fluids consitutes ordinary care. *Id.* at 35. Persons in a persistent vegetative state or coma are not the only persons who need the provision of food and fluids. Many persons need enteral feedings. Should the fact that a tube is used transform the procedure into an elective medical therapy? There is no doubt that most competent patients would elect to receive the therapy! The law prides itself on analyses which distinguish form from substance. Feeding by tube is still feeding. That a medical procedure is necessary for the insertion or maintenance of the tube does not render the food and fluids that are poured down the tube a medical treatment.

Feeding by tube is readily distinguished from medical treatment. The use of enteral feedings as required is ordinary care, not medical treatment. Any other conclusion fails to distinguish form from substance. The request of the guardian for authorization to choose death for Nancy Cruzan cannot be justified by referring to the provision of food and fluids as medical treatment.

IV. THE WITHHOLDING OF FOOD AND FLUIDS WITHOUT INFORMED CONSENT CONSTITUTES NONVOLUNTARY EUTHANASIA.

The Supreme Court of Missouri held that there was no clear and convincing evidence that Nancy Cruzan gave informed consent to the withholding of food and fluids. *Cruzan*, 760 S.W.2d at 424. Currently, there is no state in which voluntary euthanasia is legal. If voluntary euthanasia is not legal, how can nonvoluntary euthanasia be legal? The only possible way is to effect a redefinition of terms and erect an artificial distinction between active and passive euthanasia.

Active euthanasia is commonly understood to refer to the deliberate killing of a patient by acts of commission, such as lethal injection. Passive euthanasia is commonly understood to be the deliberate killing of a patient by acts of ommission, such as the withholding or withdrawal of life-sustaining treatment, or the withholding of food and fluids. At the present time, passive euthanasia and active euthanasia have been distinguished in order to make passive euthanasia more acceptable to reluctant ethicists, physicians, lawyers, and judges. However, once passive euthanasia is generally accepted, as in the Netherlands, the argument is reversed to state that there is no ethical difference between passive and active euthanasia since both actions are intended to result in the death of the patient. Bostrom, *Euthanasia in the Netherlands: A Model for the United States?*, 4 Issues in Law & Med. 467, 469 (1989) (citing Admiraal, *Justifiable Euthanasia*, 3 Issues in Law & Med. 361, 368-70 (1988)). Active euthanasia is promoted as more humane, and the ethical equivalent of passive euthanasia. Thus, passive euthanasia is a stepping stone to active euthanasia.

Ultimately, the issue of whether it is lawful to withhold food and fluids from Nancy Cruzan is not a medical issue, or even a legal issue. Ultimately, it is an ethical issue. The question is, which ethic? The guardian's alleged right to choose death for Nancy Cruzan requires a new ethical system. The traditional health care ethic, as reflected in medicine, law and ethics, supports the decision of the Missouri Supreme Court.

The May statement was drafted by a group of physicians, theologians, ethicists and attorneys and endorsed by over one hundred scholars in medicine, law and ethics. May, Barry, Griese, Grisez, Johnstone, Marzen, McHugh, Meilaender, Siegler and Smith, *Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons*, 3 Issues in Law & Med. 203 (1987). It represents the traditional view of health care ethics in that deliberate killing in any form is rejected. The May statement sets forth the following principles:

1. Human bodily life is a great good. Such life is personal, not subpersonal. It is a good of the person, not merely for the person. Such life is inherently good, not merely instrumental to other goods.

2. It is nevery morally right to deliberately kill innocent human beings — that is, to adopt by choice and carry out a proposal to end their lives. (We here set aside questions about killing those who are not "innocent," i.e., those convicted of capital crimes, engaged in unjust military actions, or otherwise unjustly attacking others.)

3. It is possible to kill innocent persons by acts of omission as well as by acts of commission. Whenever the failure to provide adequate food and fluids carries out a proposal, adopted by choice, to end life, the omission of nutrition and hydration is an act of killing by omission.

4. The deliberate killing of the innocent, even if motivated by an anguished or merciful wish to terminate painful and burdened life — deliberate killing that will henceforth be called "euthanasia" — is not morally justified by that motive.

5. Like other killing of the innocent, euthanasia can be carried out by acts of omission ("passive euthanasia") as well as by acts of commission ("active euthanasia"). The distinction makes no moral difference.

6. Euthanasia can be voluntary (of a person who gives informed consent to being killed), nonvoluntary (of a person incapable of giving informed consent), or involuntary (of a person capable of giving informed consent who does not give it).

7. Morally, for a person who consents to be killed, voluntary euthanasia is a method of suicide. Nonvoluntary and involuntary euthanasia violate not only the dignity of innocent human life but also the right of the person who is killed not to be killed. The law of homicide should continue

to apply to all forms and methods of euthanasia; none should be legalized. The law of homicide, in particular, must protect innocent human beings from being killed for reasons of mercy.

8. While competent persons have the moral and legal right to refuse any useless or excessively burdensome treatment, they must exercise great care in reaching thē judgment that a treatment is useless or excessively burdensome. This is necessary both in order to avoid any intention to end life on the grounds that it is devoid of intrinsic worth and in order to fulfill properly the responsibility to respect human life.

9. Likewise, those who have the moral duty to make decisions for noncompetent persons (such as infants or the permanently unconscious) have a moral right to refuse any useless or excessively burdensome treatment for them. This right must, however, be exercised with great care in order to avoid the temptation, unfortunately not uncommon in our society, to devalue the lives of the noncompetent or to regard such persons chiefly in terms of the utilitarian values they may represent. Too often, unfortunately, the judgment that a treatment is useless or excessively burdensome does not reflect serious consideration of the objectively discernible features of the treatment, but is an expression of attitudes toward the life being treated. Moreover, a sound public policy to protect the rights and interests of noncompetent persons and to promote the common good may require refutation by law of the scope of treatment decisions made by families and other proxies (cf. the federal "Child Abuse Amendments of 1984").

10. Human life can be burdened in many ways. But no matter how burdened it may be, human life remains inherently a good of the person. Thus, remaining alive is never rightly regarded as a burden, and deliberately killing

innocent human life is never rightly regarded as rendering a benefit.

Id. at 204-05. These principles are consistent with the common law and the laws of the State of Missouri as applicable herein.

If this Court finds in favor of the guardian, and reverses the decision of the Supreme Court of Missouri, it will have authorized and sanctioned nonvoluntary euthanasia in the United States. Such a sanctioning of euthanasia in any form will have profound consequences for Nancy Cruzan, as well as society as a whole.

V. THE NETHERLANDS IS AN ILLUSTRATION OF THE EFFECTS OF SANCTIONED EUTHANASIA ON LAW, MEDICINE AND HEALTH CARE.

The decision of the Missouri Supreme Court is supported by the alarming historical effects of sanctioned euthanasia as observed in the Netherlands.[2] The effects of sanctioned euthanasia are readily observable. Since 1973, when a lower court decision effectively opened the door to an exception to the Dutch Penal Code, the Dutch courts have been constantly expanding the boundaries of sanctioned euthanasia. *E.g.*, *Nederlandse Jurisprudentie* (Netherlands Jurisprudence, hereinafter N.J.) 1973, No. 183, District Court Leeuwarden, Feb. 21, 1973, *reprinted in part in* Verbatim, *Euthanasia Case Leeuwarden — 1973*, 3 Issues in Law & Med. 439 (1988) (W. Lagerwey trans.); *N.J.* 1987, No. 607, High Court (Penal Chamber), Oct. 21, 1986, No. 79065, *reviewed in* Nota Bene, *The High Court of The Hague, Case No. 79065, Oct. 21, 1986*, 3 Issues in Law & Med. 445 (1988). Candidates for euthanasia now include not only older persons, but youthful multiple sclerosis patients as well. Feber, *De wederwaardigheden van artikel 293 van het Wetboek van Strafrecht vanaf 1981 tot heden* (The Vicissitudes of Article 293 of the Penal Code from 1981 to the Present), in *Euthanasie Knelpunten in Een Discussie* (Euthanasia: Bottlenecks in a Discussion) 54-81 (G. van der Wal ed. 1987), *reviewed in* Abstracts, 3 Issues in Law & Med. 455, 461 (1988). Dr. Sven Danner, of the Amsterdam Medical Center, where 75% of all Netherlands patients with AIDS are treated, reports that one in eight AIDS patients receive euthanasia. Gonggrijp, *Euthanasie bij een op de acht aids-patienten* (Euthanasia in One of Eight AIDS Patients), De Telegraaf (Dutch newspaper), Feb. 4, 1987 (W. Lagerwey trans.). The majority of the State Commission on Euthanasia supports nonvoluntary euthanasia for persons who have irreversibly lost consciousness (technically, the judicial exception to the Dutch Penal Code only permits voluntary euthanasia). C. Dessaur & C. Rutenfrans, *Mag de Dokter Doden?* (May the Doctor Kill?) 110 (1986) (quoting from *Staatscommissie Jeukens, geciteerd in: Persinformatie over Eindrapport van de Staatscommissie Euthanasie* (State commission Jeukens, *cited in* Press Information on the Final Report of the State Commission on Euthanasia), Aug. 19, 1985, at 4). This expansion of indications for euthanasia will no doubt be replicated in the United States once euthanasia in any form is sanctioned by this Court. Our experience in abortion law too readily confirms that tendency in law and human nature.

Second, the Dutch experience has demonstrated the uncontollable nature of euthanasia. Official death registrations in the Netherlands indicate that three thousand persons per year are terminated by doctors on the patient's request. Schepens, *Euthanasia: Our Own Future*, News Exchange, Oct. 1987, at 5, *reprinted in* 3 Issues in Law & Med. 371, 373 (1988). The official figure is acknowledged to be low because thousands of acts of euthanasia are never reported due to the routine falsification of death certificates by doctors who wish to avoid investigation and prosecution. Feber, *supra*, at 467-68. The point is that no one knows for sure how many people are

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[2] *See generally*, Bostrom, *Euthanasia in the Netherlands: A Model for the United States?* 4 Issues in Law & Med. 467 (1989) (Based on first hand accounts by Dutch scholars translated from the Dutch language, this article presents evidence that illustrates the effect of sanctioned euthanasia on medicine, law and health care in the Netherlands.).

euthanized each year, whether such acts were voluntary, nonvoluntary or involuntary. Euthanasia is too easily performed and too easily concealed to be subject to any reasonable safeguards. In short, it is uncontrollable.

Third, the sanctioning of euthanasia has produced fear in Dutch nursing home residents. In a recent study of the views of older persons on the subject of euthanasia, it was determined that 95% of the persons interviewed in Dutch nursing homes were opposed to the legalization of euthanasia. J. Segers, *Ouderen Over Euthanasie* (Elderly Persons on the Subject of Euthanasia) (1987), *reprinted in* Segers, *Elderly Persons on the Subject of Euthanasia*, 3 Issues in Law & Med. 407, 420 (1988) (W. Lagerwey trans.). Fifty to sixty percent were fearful of involuntary euthanasia. *Id.* at 422. Three quarters of the nursing home residents and nearly one half of those older persons living independently were absolutely opposed to others (including family members and their treating physician) making decisions concerning termination of their lives if they are incompetent to decide for themselves. *Id.* at 424. Dutch sociologist, Dr. Hilhorst, reports that more requests come from the patients' families than from the patients themselves. He also found that not only the family, but also the nursing personnel and doctors often put pressure on the patient to request euthanasia. C. Dessaur & C. Rutenfrans, *supra*, at 73-74, 76. Dr. Fenigsen, a Dutch cardiologist, has remarked that, as a rule relatives request euthanasia because they say the patient cannot tolerate any further suffering. He states, "They honestly believe this . . . . They do not realize that they themselves can no longer tolerate the situation." R. Fenigsen, *Euthanasie: Een Weldaad?* (Euthanasia: A Blessing?) 68 (1987). Sanctioned euthanasia has destroyed the ethical integrity of the medical profession and the relationship of trust in the physician-patient relationship for many older persons.

Fourth, at the same time that euthanasia is receiving so much attention in the Netherlands, there is a coincidental reduction of public health care benefits for the care of older

persons. Extensive reductions are being made in public health care funding without investigation of the effects upon the health care of older persons. Kroon, *Introduction*, in Segers, *supra*, at 409. Could it be that the engine for euthanasia is economic or political instead of humanitarian? These funding reductions are occurring simultaneously with a growing population of older persons. Dr. Kroon, a Dutch physician, posses the following question: "To what extent are requests for euthanasia on the increase because adequate care is no longer being provided for the elderly?" *Id.* at 409-10. He cites a report that requests for euthanasia decrease when care includes "nearness, showing understanding, listening, an optimal number of contacts, a good doctor-patient relationship, and effective combating of physical symptoms." *Id.* Certainly euthanasia appears to be an economical way to dispose of older persons and persons in a persistent unconscious state.

Fifth, there is no consensus of opinion in Holland on the practice of euthanasia. The doctors are as divided as the rest of society. Some polls show 70% of the people and doctors as favoring euthanasia. R. Fenigsen, *supra*, at 95. Other polls show substantial percentages of people who favor involuntary euthanasia, i.e. mercy killing without request. C. Dessaur & C. Rutenfrans, *supra*, at 29, 32-34 (quoting an *AVRO* Dutch television network poll conducted Jan. 13, 1986, and a *NIPO* (Dutch opinion poll organization) poll on Dutch attitudes about euthanasia).[3] The Penal Code has not been amended precisely

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[3] These polls prove too much. Apparently there are many people who approve of involuntary euthanasia at a time when the medical-legal-political discussion concerns only voluntary euthanasia. The statistics perhaps explain the research demonstrating that the vast majority (95%) of nursing home residents are opposed to the legalization of euthanasia.

because there is so little agreement on when and how euthanasia is to be performed.[4]

The Netherlands offers a unique opportunity to assess the results of sanctioned euthanasia upon law and medicine. When the results of that social experiment are analyzed, it is clear that the Netherlands experience is a model of that which is to be avoided, not followed.

The reality of euthanasia in the Netherlands is alarming. This is reflected in the writings of physicians, jurists, and others who live there. The Netherlands may be touted as a model for the United States only by those who obscure that reality. Sanctioned euthanasia in any form is a dangerous step because (1) the boundaries of such acts tend to include ever broader categories of persons medically dependent and disabled; (2) abuses are so easily concealed and so difficult to prosecute; (3) the effect is to diminish medical professionalism and efforts to save lives; (4) the acceptance is fueled by the convenience of reducing public health care costs at a time when the population of older persons is expanding; and (5) the fear of involuntary euthanasia grows creating a distrust of physicians and family members. Bostrom, *supra*, at 485.

The primary motives which underlie the present press for sanctioning euthanasia seem to be (1) the fear of personal suffering; (2) prejudice and discrimination against persons who are older, ill, or disabled and whose quality of life appears to be so low that third persons decide they are not worth saving; and

[4] The State Commission on Euthanasia states "[I]t will take many more years before the desired clarity develops with regard to the limits of criminalization in regard to euthanasia." Driesse, Van der Kolk, Van Nunen Forger & Van Swinderen, *Euthanasie en het recht in Nederland* (Euthanasia and the Law in The Netherlands), in *Op Leven en Dood* (A Matter of Life and Death), *reprinted in Euthanasia and the Law in The Netherlands*, 3 Issues in Law & Med. 385, 395 (1988) (W. Lagerwey, trans.) (quoting the advice of the State Commission on Euthanasia to the Queen, July 9, 1985.).

(3) pressure to reduce health care costs. None of the above motives justify the radical changes proposed in law and medicine. Instead, they must be recognized as pressures which distort rational decisionmaking in health care.

The inadequacies of a myopic emphasis on an individual's "right to die" by legal scholars who favor the sanctioning of euthanasia are exposed by the light of the realities of euthanasia in the Netherlands. Worst case scenarios prey upon our personal fears and seem to bolster the case for a "right to die." But no one lives in a vacuum. Law, medicine and health care should not be manipulated in order to satisfy some unprincipled version of constitutional rights for decisionmaking in a worst case scenario. Instead, law, medicine and health care should be designed to err, if at all, on the side of the preservation of life and the establishment of rational principles for the protection of the most vulnerable persons in society — those who are medically dependent and disabled. A right to die, once accepted, too easily becomes a duty to die, or an excuse to kill.

There is no consensus of opinion in the United States on the morality of euthanasia. Why should this Court create a judicial exception to the penal codes of the fifty states in recognition of an ethical position only recently postulated and avocated in American jurisprudence? To do so would have the effect of removing the debate from the state legislatures and state courts and open a Pandora's Box of litigation regarding the acceptable circumstances and persons to receive the "benefit" of euthanasia by starvation or other methods. The myriad of persons with conditions of varying degrees of mental and physical disability could produce a volume of litigation which dwarfs that produced by this Court's decision in *Roe v. Wade*, 410 U.S. 113 (1973). This Court lacks a constitutional justification to reverse centuries of tradition in law, medicine, and health care ethics.

CONCLUSION

Feeding by tube is not physicially or economically burdensome. It is a safe and effective way of providing nutrition to persons unable to ingest food by mouth. As an alternative to oral ingestion, such feedings constitute ordinary care, not medical treatment. Since the presence of the tube is not an issue, the only issue is whether food and fluids should be withheld in order to cause the death of Nancy Cruzan, a person who is not terminally ill, and for whom no clear and convincing evidence has been presented as to her intentions. The authorization of the withholding of nutrition from Nancy Cruzan by this Court would confirm a constitutional right in a guardian to choose death for a dependent ward. It would constitute a dangerous precedent in the law which would not only cause the death of Nancy Cruzan, but would place at risk thousands of persons who are incompetent and reliant on feeding by tube. It would constitute the legalization of nonvoluntary euthanasia in the United States. For these reasons, the American Academy of Medical Ethics respectfully requests this Court to affirm the holding of the Supreme Court of Missouri in *Cruzan v. Harmon*.

Respectfully submitted,

James Bopp, Jr.
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Counsel for the
American Academy of
Medical Ethics

Appendix

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Appendix A: Letter from Donald Lamkins, Administrator of the Missouri Rehabilitation Center, dated August 10, 1989.

A New Day

MRC

Missouri Rehabilitation Center

Mt. Vernon, Missouri 65712
Phone 417-466-3711

Donald C. Lamkin
Director

August 10, 1989

Melinda Saul
National Legal Center
P.O. Box 441069
Indianapolis, Indiana 46244

Dear Ms. Saul:

Following is information you asked for regarding the cost of caring for Nancy Cruzan. The form is not exactly as you requested, but we don't keep records in the detail that you asked for. I hope this will be sufficient for your purpose.

	Monthly Amount
Room and Board	$5,250.00
Medical Supplies	1,735.32
Special nutritional supplement	234.00
Respiratory Therapy	280.00
Medicine	954.00
Physician's hospital fees	391.00
Total	$8,844.32

Room and board charges include nursing expenses, general overhead expenses such as laundry, linens, miscellaneous supplies, and general overhead costs. This is figured in the room and board charge of $175 per day.

If you need further breakdown of any of these items we may be able to get it for you. If you have any questions, please do not hesitate to call.

Sincerely,

Donald C. Lamkin
Center Director

DCL:vlc

c Bob Presson